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Missouri Division of Medical Services

www.dss.state.mo.us/dms

DME Bulletin

IMPORTANT INFORMATION REGARDING THIS BULLETIN

Due to budget constraints no paper copies of this bulletin will be printed or mailed. This bulletin is only available on the Internet at the DMS website, www.dss.state.mo.us/dms. This bulletin will be posted at this location and will remain until it is incorporated into the provider manuals as appropriate. At that time, the bulletin will be deleted from this site.

MC+ MANAGED CARE PROGRAM

MC+ managed care health plans provide DME benefits to their enrollees. Coverage of DME items under MC+ managed care is the same as for fee-for-service.

Billing requirements outlined in this bulletin apply to services provided to MC+ and Medicaid recipients who receive their services on a fee-for-service basis.

Check with the MC+ managed care health plans for their billing requirements.

HOME PARENTERAL NUTRITION REIMBURSEMENT CHANGES

Missouri Medicaid began using the first quarter 2002 Medicare fee schedule to reimburse Home Parenteral Nutrition (HPN) and supplies, December 1, 2002.

HOME PARENTERAL NUTRITION LIMITATIONS

One supply kit (B4220 or B4222) and one administration kit (B4224) will be covered for each day that parenteral nutrition is administered, when such kits are used and medically necessary.

HOME PARENTERAL NUTRITION BILLING REQUIREMENTS

No separate attachments are required for billing HPN unless otherwise indicated in Attachment A, page 2. Documentation of medical necessity and documentation to support coverage must be kept in the recipient's file by the provider who bills for the HPN service. Documentation must include the specific prescription from the prescribing physician which includes anticipated duration of HPN, diagnosis related to the recipients inability to consume regular food and amount of HPN needed per day. The Home

Parenteral Nutrition Medical Necessity form is no longer a required attachment to be submitted with the claim for payment.

When homemix parenteral nutrition solutions are used the component carbohydrates (B4164, B4180), amino acids (B4168, B4178), additives (B4216), and lipids (B4184, B4186) are separately billable. When premix parenteral nutrition solutions are used (B4189-B4199, B5000-B5200), there must not be separate billing for the carbohydrates, amino acids, or additives (vitamins, trace elements, heparin, electrolytes). Lipids (B4184, B4186) are separately billable with premix solutions. Invoice of Cost is required when billing for B5200.

Parenteral nutrition procedure codes that are defined as one unit equals one day may be billed by date of service or by consecutive dates of service. Claims for individuals receiving parenteral nutrition on Monday, Wednesday, and Friday must be billed by date of service while claims for individuals with daily infusions should be billed with a from and through date of service. The number of units billed must equal the number of days when billing consecutive from and through dates of service.

Parenteral nutrition procedure codes that are defined as one unit equals 500 ml (B4168, B4172, B4176, B4178, B4180, B4184, B4186) must be billed as such. These procedure codes should be billed on the date the item is initially dispensed regardless of the number of days it covers.

A Certificate of Medical Necessity (CMN) is required when billing for B9999 (parenteral supplies not otherwise classified). The CMN must include a clear description of the item, quantity provided, and justification for why the item(s) are needed. An invoice of the cost of the item, must be submitted with the claim form. If the physician has determined that a recipient will require HPN for more than six months, the HPN pump should be purchased. Conversely, if the anticipated length of need is six months or less the pump should be rented.

Parenteral Nutrition procedure codes Z0201, Z0202, Z0203, Z0204 and Z0200 are being deleted effective March 1, 2003 (See Attachment A, page 1-2).

EQUIPMENT

Effective May 1, 2003, the following procedure codes have been reduced to the 2002 Medicare maximum allowed amount; E0110, E0155, E0176, E0177, E0178, E0184, E0185, E0202, E0272, E0940, E0967, E0969, and E0977. (See Attachment A, page 2-3).

Effective March 1, 2003, procedure code E0192 (low pressure and equalization pad for wheelchair) has been added as a covered HCPCS code with a Medicaid maximum allowable of $295.00. This code is to be used when billing for cushions such as Roho or Jay.

Effective May 1, 2003, Missouri Medicaid will no longer reimburse for an Event Recorder - Y9052 or a Pneumogram - Y9053. Most modern apnea monitors have the capacity to provide event recordings. Reimbursement for the apnea monitor - E0608 will include all supplies such as electrodes, wires and belts, repair, maintenance, initial set up professional support, event recording, and pneumogram.

ORTHOTIC AND PROSTHETIC DEVICES

Effective March 1, 2003, a Medicaid maximum allowable fee has been established for those orthotic and prosthetic codes that are currently manually priced.

Effective May 1, 2003, the following procedure codes have been reduced to the 2002 Medicare maximum allowed amount; L0120, L0140, L0210, L0320, L0540, L1030, L1660, L1800, L1825, L1920, L2020, L2112, L2188, L2415, L3906, L3986, L5020, L5050, L5410,

L5430, L5614, L5651, L5655, L5850, L5974, and L6730. (See Attachment A, page 3-10).

AUGMENTATIVE COMMUNICATION DEVICES

Effective May 1, 2003, the reimbursement for augmentative communication devices and accessories will be reduced from 90% of manufactures suggested retail to 85% of manufacturers suggested retail.

OXYGEN

Effective May 1, 2003, the reimbursement for oxygen and oxygen delivery systems will be reduced by 5 %. (See Attachment A, page 11).

DIAPERS

Effective March 1, 2003, a Medicaid maximum allowable amount of .50 cents each has been established for disposable diapers/pullups (S8401, S8403, S8404). Diapers/pullups in excess of 186 per recipient, per month will continue to require written justification from the prescribing physician explaining the specific medical reason for diapers/pullups in excess of this limit. Prior authorization requests for diapers/pullups must show the number requested per month in the units field of the Prior Authorization Request form. Prior authorization for diapers may be requested for up to 12 months. The invoice of cost is no longer a required attachment when requesting prior authorization. When submitting claims for diapers one unit equals one diaper/pullup.

DURABLE MEDICAL EQUIPMENT (DME) BILLING CLARIFICATION

As stated in Question 8 of the Special Bulletin, Volume 25, No. 1 dated September 6, 2002, "Providers should only bill services through the end of the month for any Medicaid recipient." Since October 1, 2002, claims must be submitted on a calendar month basis for all spenddown recipients. If authorization was given beyond the end of a month, providers must bill the September, 2002, billing from the approval date to the end of September, 2002. The next month billing must then begin with October 1, 2002, through October 31, 2002, etc. If claims have been submitted with dates extending into the next month, that claim will deny, and a new claim **must** be resubmitted.

The Division of Medical Services (DMS) is in the process of correcting DME rental prior authorization requests to allow the last month of service to pay. This correction will authorize service through the last day of the month in which the Prior Authorization (PA) ends and authorize one (1) extra unit to allow the partial month to pay as well as the last full month. Providers **should not** bill for the last month of the PA until they receive notification from DMS that the PA has been corrected.

Provider Communications
(800) 392-0938
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(573) 751-2896